



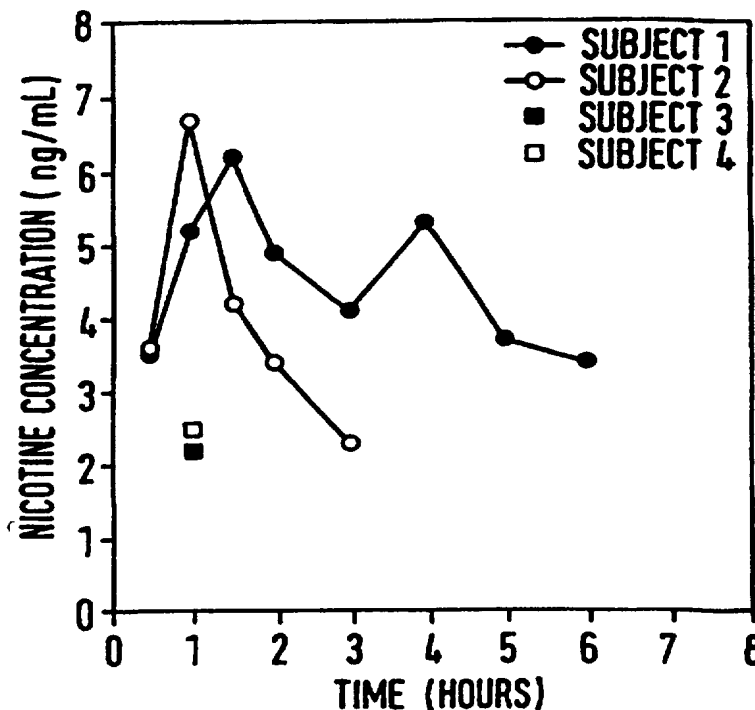
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(54) Title: INTESTINAL ABSORPTION OF NICOTINE TO TREAT NICOTINE RESPONSIVE CONDITIONS

(57) Abstract

Nicotine is absorbed systemically from the intestine in therapeutic amounts for the treatment of nicotine responsive conditions, particularly inflammatory skin conditions, Alzheimer's disease, schizophrenia, Parkinson's disease, Tourette's syndrome, depression and to assist in the cessation of smoking. The nicotine is ideally delivered for absorption from the colon as a nicotine-polyacrylate complex in a sustained and delayed released enteric coated capsule. In this way, the high peak plasma levels, which normally give rise to side-effects associated with nicotine are reduced.



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INTESTINAL ABSORPTION OF NICOTINE TO TREAT NICOTINE RESPONSIVE CONDITIONS

The present invention relates to the use of nicotine
5 composition delivered for absorption from the intestine,
particularly the ileum and colon, for the treatment of
nicotine responsive conditions particularly
schizophrenia, Alzheimer disease, Tourettes syndrome,
Parkinsons disease, depression (particularly associated
10 with cessation of smoking), inflammatory skin conditions,
and as an aid to cease smoking.

Cigarette smoking has been reported as altering the
inflammatory response in the skin following application
15 of irritants and rubefacients (Mills et al, BMJ
1993;307:911). In a follow up study, Mills administered
nicotine via a transdermal delivery system and was found
to suppress the cutaneous inflammatory response to sodium
lauryl sulphate (irritant) and UVB radiation, as well as
20 reactive hyperaemia following arterial occlusion
(Workshop on Nicotine as a Therapeutic Agent - 15 May
1996, Frankfurt, Germany). In the same workshop,
Sandberg et al reported that administration of nicotine
(either 2mg nicotine gum or 7mg transdermal nicotine
25 patch) along with neuroleptics produce a decrease in tic
symptoms in patients suffering from Tourette's syndrome.

A beneficial response of Alzheimer and Parkinsons
disease patients to nicotine was also reported at the
workshop.

30

However, nicotine has a substantial effect on the
cardiovascular system including increased heart rate and
blood pressure resulting in greater myocardial work and
oxygen requirement and coronary vasoconstriction.
35 Nicotine has also be purported to activate platelets and
to adversely affect blood lipids, thereby promoting

atherosclerosis and increasing the risk of acute coronary events. Furthermore nicotine from tobacco products has also been associated with an increased risk of cancer and cerebral haematoma.

5

Known delivery routes for nicotine are via cigarette smoking, inhalers, nasal spray, polacrilex gum and transdermal patch. Inhalers and nasal sprays deliver nicotine rapidly to the blood plasma in high peak
10 concentrations and can therefore give rise to addictive cravings similar to cigarette smoking. The use of nicotine gum and transdermal patches are reported at the aforementioned Nicotine Workshop, and are used extensively to aid in the cessation of smoking. However
15 long term administration of a nicotine patch is limited by a relatively high rate of dermatological side effects, especially in the elderly. Patients have also reported side effects such as nausea, headaches, tremor and vomiting, thereby again limiting patient compliance.
20 Polyacrilex gum again relies heavily on good patient compliance. The amount of nicotine delivered depends on the rate and length of chewing and therefore it is difficult to achieve a controlled uniform plasma concentration of nicotine.

25

It is an object of the present invention to obviate or mitigate the aforesaid disadvantages.

It is a further object to provide for delivery of
30 nicotine which is convenient and where side effects of nicotine is limited, while still providing a beneficial effect on conditions susceptible to treatment with nicotine.

35 The inventors have now found that the blood plasma concentration of nicotine can be controlled to

therapeutic levels while limited the adverse side-effects if nicotine is absorbed from the small or large intestine. For example nicotine can be delivered rectally, such as by an enema, to the large intestine or
5 as a post-gastric delayed release oral (DRO) composition to the small and/or large intestine. In this way the nicotine is absorbed more slowly into the blood plasma over a sustained time period thereby decreasing the peak plasma concentrations which typically induces nicotine
10 dependency. It also avoids the dermatological side-effects of a transdermal patch, and the uncertain effectiveness of nicotine chewing gum. Thus therapeutic levels of nicotine can be delivered to treat the aforementioned conditions while reducing the adverse
15 side-effects normally associated with nicotine.

Accordingly in a first aspect of the invention there is provided the use of nicotine or a pharmacologically acceptable derivative or metabolite thereof in the
20 preparation of a medicament which is adapted for absorption from the small and/or large intestine for the treatment or prophylaxis of inflammatory skin conditions, schizophrenia, Alzheimer disease, Parkinsons disease, Tourettes syndrome, depression, or to assist in the
25 cessation of smoking. In fact, nicotine according to the invention could be use therapeutically in any disease state in which an association with non-smoking or smoking status would suggest a therapeutic role for nicotine. For the avoidance of doubt, absorption from the small
30 and/or large intestine includes from the pylorus to the anus.

Examples of inflammatory skin conditions susceptible to the invention are acne, reigacne vulgaris and rosacea.
35 With Alzheimer patients, the invention will typically improve their attentional function. Depression,

particularly associated with the cessation of smoking, is susceptible to treatment with the invention.

5 A further aspect of the invention comprises a method for the treatment of nicotine responsive conditions, particularly those disclosed herein, comprising administering to the patient an effective amount of a rectally administrable or DRO composition as defined in the first aspect of the invention.

10

Co-pending International No. PCT/GB97/00369 and US application Nos. 08/605,319 and 08/794,668 relate to the use of nicotine delivered for sustained release from the colon for the treatment of inflammatory bowel disease, and therefore this nicotine responsive condition is not within the scope of the present condition.

Although there is some benefit in having absorption of nicotine from anywhere in the small or large intestine, it is most preferred that absorption occurs predominantly in the colon. This in the case of a post-gastric delayed release oral (DRO) composition, the composition will pass through the small intestine in about 4 to 8 hours and will then reside in the colon for about 48 hours. Furthermore nicotine is absorbed more slowly in the colon than in the small intestine. Therefore nicotine delivered for absorption predominantly in the colon will be absorbed more slowly over a sustained period and will give rise to a more uniform blood plasma concentration, and will reduce the peak concentration of nicotine which otherwise cause dependence and adverse side-effects.

By predominant absorption from the colon, we mean to include at least 70%, more preferably at least 80%, such

as at least 85% or at least 90% of the total dose of nicotine.

In a preferred embodiment, a DRO composition is delivered for dissolution in the ileum, more particularly the terminal ileum so that most of the nicotine would be released and absorbed in the colon.

The most preferred form of the invention is a sustained and post-gastric delayed released composition.

In this form, the effect of the nicotine being absorbed more slowly and at more uniform concentration levels into the bloodstream from the small and/or large intestine, is enhanced because the composition also controls the release of the nicotine over a sustained time interval. This form of the invention is of particular benefit, where most of the nicotine is released and absorbed in the colon i.e. the composition resides here for the longest time period. Thus in a preferred embodiment the invention relates to use of nicotine given orally as a sustained release DRO composition (advantageously having an enteric coating) for the treatment of nicotine responsive conditions.

Various sustained release compositions of nicotine are described later and include nicotine being present as a nicotine-polyacrylate complex, nicotine is an amphiphilic polyglycolized glyceride matrix, and using various enteric coated microgranules containing nicotine in an enteric coated capsule. A preferred form of saturated polyglycolized glyceride is gelucire™, particular gelucire 44/14 and 53/10.

By pharmacologically acceptable derivatives and metabolites of nicotine we mean derivatives which exhibit pharmacotherapeutic properties similar to said active

agent. This includes pharmacologically acceptable salts, esters and salts of such esters.

Any pharmacologically acceptable derivative or
5 metabolite of nicotine which exhibits pharmacotherapeutic properties similar to nicotine may be used in practising the invention. Such derivatives and metabolites are known in the art (Glenn et al J. Org. Chem., 43:2860-2870 (1978); Dominiak et al., Klin Wochenschr, 63:90-92
10 (1985)) and include nicotine oxide and cotinine.

A particular characteristic property of nicotine is its ability to form salts with almost any acid and double salts with many metals and acids. The acids that may be
15 used to prepare the pharmaceutically acceptable acid salts of nicotine are those that form non-toxic acid salts, i.e., salts containing pharmacologically acceptable anions, such as hydrochloride, hydrobromide, hydroiodide, nitrate, sulphate or bisulphate, succinate, maleate, fumarate, bitartrate, gluconate, saccharate,
20 benzoate, methanesulphonate, ethanesulphonate, benzenesulphonate, p-toluene sulphonate, camphorate and pamoate salts. Particularly preferred is the tartrate and bitartrate
25 salts.

Preferably nicotine is present in a complex with a polyacrylic acid polymer to form a nicotine-polyacrylate complex, preferably a water-soluble complex.
30

Preferably, the polyacrylate is a carbomer, such as those described in the British Pharmacopoeia and defined in CAS 54182-57-9. Carbomers are synthetic high molecular weight polymers of acrylic acid cross-linked
35 with allylsucrose, and contain 56 to 68% carboxylic acid groups.

When used in accordance with an oral dosage form of the invention the carbomers hydrate and swell to form a gel, which retards the nicotine release and absorption.

- 5 A complex of bismuth and carbomer is disclosed in EP-A-0540613.

Convenient modes of administration to deliver the sustained release composition for absorption from the
10 colon are rectal compositions such as enemas and suppositories, and DRO compositions such as enteric coated tablets, capsules, powder or granules.

Typical enema formulations comprise an effective
15 amount of nicotine dissolved or dispersed in a suitable aqueous flowable carrier vehicle. The carrier vehicle is preferably thickened with natural or synthetic thickeners such as gums, acrylates or modified celluloses. The formulation can also comprise an effective amount of a
20 lubricant such as a natural or synthetic fat or oil, e.g. a tris-fatty acid glycerate or lecithin. Nontoxic nonionic surfactants can also be included as wetting agents and dispersants. Unit dosages of enema formulations can be administered from prefilled bags or
25 syringes. The carrier vehicle may also comprise an effective amount of a foaming agent such as *n*-butane, propane or *i*-butane. Such formulations can be delivered from a preloaded syringe pressurised container, so that the vehicle is delivered to the colon as a foam, which
30 inhibits its escape from the target site.

A dosage form of nicotine adapted for either rectal or oral delivery may also be complexed with a suspending or thickening agent to prolong release of the dosage form
35 of nicotine. Such agents include methacrylic acid polymer or acrylic acid polymers, preferably carbomers

(carboxypolymethylene) which are synthetic high molecular weight acrylic acid polymers crosslinked with polyfunctional moieties such as polyallylsucrose. Generally, carbomers comprise 50 to 70% carboxylic acid groups.

In a preferred embodiment, an active agent/carbomer complex may be administered rectally as liquid enemas. Liquid enemas are prepared essentially as described above by forming an effective amount of a nicotine/carbomer complex in a suitable flowable liquid carrier. The carrier vehicle is preferably thickened with thickeners and can also comprise an effective amount of a lubricant. Unit dosages of enema formulations can be administered from prefilled bags or syringes.

The pH of the enema should be 3.0 to 3.5 before a buffering solution is added to raise the pH to between 4.5 to 5.5, ideally about pH 5.0 (at which patients feel comfortable).

In a carbomer formulation this can be achieved by adding quantities of a suitable amine protein acceptor to the preparation. At the same time such a preparation also neutralises some of the carbomer molecules thereby increasing the viscosity. Preferably trometamol is used as a buffering and thickening agent in an enema composition. On average each 100 ml of enema requires about 6 ml (viscosity 4.5 to 7.5 mNm) of a 1% solution of trometamol to give a final acceptable pH of about 5 and viscosity of 3 to 6.5 mNm, ideally 4.0 mNm.

In general where the nicotine is administered rectally, a suitable dose will be in the range of from 0.001 to 1.5 mg/Kg, preferably in the range of 0.01 to 0.20 mg/Kg, most preferably in the range of 0.04 to 0.10

mg/Kg, calculated as nicotine in the free base form. Preferably, nicotine is rectally administered once or twice daily.

5 When the active agent is administered orally via a tablet, capsule or granules, preferably the dosage form will have an enteric coating which dissolves in the ileum so that the active agent can predominantly be absorbed from the colon.

10

 In general, where the nicotine is administered orally, a suitable dose will be in the range of from 0.001 to 1.5 mg per day preferably in the range of 0.01 to 20 mg per day most preferably in the range of 0.04 to 15 mg per day, calculated as nicotine in the free base form. Preferably, nicotine is orally administered 1 to 4 times daily, for example 3-4 times daily, although more frequent dosing is contemplated where hourly dosing is desired.

20

 The compound is conveniently administered orally in unit dosage form; for example, containing 1 to 36 mg, conveniently 3 to 30 mg, such as 6 to 30 mg, and such as 15 to 30 mg of active ingredient per unit dosage form. 25 In a preferred embodiment of the invention 3 mg to 6 mg was useful.

 An effective amount of nicotine can be administered to the intestine, preferably the colon of the patient by 30 oral ingestion of a unit dosage form such as a pill, tablet, powder or capsule, comprising an effective amount of nicotine which is enterically coated so as to be released from the unit dosage form in the lower intestinal tract, e.g., in the ileum and in the colon of 35 the patient. Enteric coatings remain intact in the stomach, but will dissolve and release the contents of

the dosage form once it reaches the region where the pH is optimal for dissolution of the coating used. The purpose of an enteric coating is to substantially delay the release of the nicotine until it reaches its target
5 site of action in the ileum or colon.

Thus, a useful enteric coating is one that remains intact in the low pH environment of the stomach, but readily dissolved when the optimum dissolution pH of the
10 particular coating is reached. This can vary between pH 3 to 7.5 depending upon the chemical composition of the enteric coating, but is preferably between about pH 6.8 and pH 7.2. The thickness of the coating will depend upon the solubility characteristics of the coating
15 material and the site to be treated.

In general coating thicknesses of about 25 to 200 μm , and especially 75 to 150 μm , are preferred using about 3 to 25 mg, preferably 8 to 15 mg of acidic coating
20 material per cm^2 of tablet or capsule surface. The precise coating thickness will however depend upon the solubility characteristics of the acidic material used and site to be treated.

25 When used in accordance with an oral dosage form of the invention the carbomers hydrate and swell to form a gel, which retards the nicotine release and absorption.

The most extensively used polymer for enteric coating
30 is cellulose acetate phthalate (CAP). However, CAP has an optimum dissolution pH greater than 6, thus early drug release may occur. Another useful polymer is polyvinyl acetate phthalate (PVAP) which is less permeable to moisture and gastric fluid, more stable to hydrolysis and
35 able to dissolve at a lower pH, which could also result in early release of nicotine in the duodenum.

Another available polymer is hydroxypropyl methylcellulose phthalate. This has similar stability to PVAP and dissociates in the same pH range. Further
5 examples of currently used polymers are those based on methacrylic acid, e.g., methacrylic acid ester copolymers with acidic ionizable groups, such as Eudragit L (particularly L30D) and S (methacrylic acid copolymer) and mixtures thereof. Dosage forms coated with
10 Eudragit™, which dissolve in the ileum at about pH 6.8, and in the terminal ileum and caecum at about pH 7.2, have been developed for delivery of 5-aminosalicylic acid, and are particularly preferred in accordance with the invention. These coatings will deliver most of the
15 active for absorption in the colon, although some will be absorbed at the site of dissolution of the coating (e.g. terminal ileum and/or caecum).

In general, where the nicotine is administered
20 orally, a suitable dose will be in the range of from 0.001 to 1.5 mg per day preferably in the range of 0.01 to 20 mg per day most preferably in the range of 0.04 to 15 mg per day, calculated as nicotine in the free base form. Preferably, nicotine is orally administered 1 to 4
25 times daily, for example 3-4 times daily, although more frequent dosing is contemplated where hourly dosing is desired.

The compound is conveniently administered orally in
30 unit dosage form; for example, containing 1 to 36 mg, conveniently 3 to 30 mg, such as 6 to 30 mg, and such as 15 to 30 mg of active ingredient per unit dosage form. In a preferred embodiment of the invention 3 mg to 6 mg was useful.

35

In a preferred embodiment a capsule is enteric coated and contains a plurality of granules containing the active agent which also are enterically coated. The enteric capsule coating is insoluble in the pH medium of the stomach, but dissolves in the pH of the small intestine, preferably the ileum, to release the enterically coated granules. These coated granules are insoluble in intestinal juice below about pH 7, but are soluble in colonic intestinal juice. The beads have different enteric coated polymers and thicknesses of coatings to provide a sustained release of the active agent for absorption from the colon. Suitable coatings are Eudragit L, S, R, L, RL and RS. A capsule such as above is described in more detail in US-A-5,401,512 and WO-A-9214452, the teachings of which are incorporated herein by reference.

In another preferred oral dosage form, the active agent is complexed with a carbomer which is itself coated with an acrylic resin and contained in an enterically coated capsules. The capsule coating dissolves in the intestinal juices such as those of the small intestine, preferably the ileum, to deliver the active agent/carbomer complex to the colon.

A suitable alternative formulation would be to incorporate the nicotine or its salts, more preferably the nicotine carbomer complex into heat-meltable ampiphilic excipients such as partial glycerides and polyglycerides of fatty acids of the Gelucire™ type (available from Gattefosse, France) or polyoxyethylene glycols, filled into hard gelatine capsules and coated with either cellulose derivative or acrylic polymer enteric coating.

Carbomers are available as fine white powders which disperse in water to form acidic colloidal suspensions (a 1% dispersion has approx. pH 3) of low viscosity. Neutralisation of these suspensions using a base, for example sodium, potassium or ammonium hydroxides, low molecular weight amines and alkanolamines, results in the formation of clear translucent gels. Nicotine and its salts form stable water-soluble complexes with carbomers at about pH 3.5 and are stabilised at an optimal pH of about 5.6.

Preferably, the carbomer is Carbopol. Such polymers are commercially available from B.F. Goodrich under the designation Carbopol[™] 420, 430, 475, 488, 493, 910, 934, 934P, 974 and 974P. Carbopols[™] are versatile controlled-release polymers, as described by Brock (Pharmacotherapy, 14;430-7(1994)) and Durrani (Pharmaceutical Res. (Supp.) 8;S-135 (1991)), and belong to a family of carbomers which are synthetic, high molecular weight, non-linear polymers of acrylic acid, crosslinked with polyalkenyl polyether. In a particularly preferred embodiment the carbomer is Carbopol[™] 974P NF.

To prepare, for example, a nicotine/carbomer complex the carbomer is suspended in a appropriate solvent, such as water, alcohol or glycerin. Preferably, the carbomer is mixed with water, preferably de-ionised water. Mixtures may range, for example from 0.002 to 0.2 g of carbomer per ml of solvent, preferably from 0.02 to 0.1 g of carbomer per ml of solvent. The mixture is stirred thoroughly at room temperature until a colloidal suspension forms. The dispersion may be stirred using a suitable mixer with a blade-type impeller, and the powder sieved into the vortex created by the stirrer using a 500 micron brass sieve. This technique allows ample wetting of the powder and prevents the powder from forming a

cluster of particles which then become difficult to wet and disperse.

The nicotine or nicotine salt may be diluted with any
5 pharmaceutically acceptable organic solvent. In a preferred embodiment, the solvent is an alkanol such as ethanol. Mixtures may range, for example, from 0.01 to 10 g of nicotine per ml of solvent, preferably from 0.5 to 5 g of nicotine per ml solvent. This solution is then
10 added drop wise to the carbomer suspension and mixed continuously until a gel of uniform consistency has formed. Preferably, the nicotine/complex is made by combining 1 g of nicotine or nicotine salt with from 0.1 to 100 g of carbomer, more preferably with 1 to 50 g of
15 carbomer. A gradual thickening of the suspension occurring as neutralisation of the carbomer takes place. The preparation will now take on the appearance of a slightly white translucent gel. This physical change in viscosity and appearance is consistent with
20 neutralisation of the acid by the base.

The gel is then dried. According to one embodiment, the gel is vacuum dried. By way of example, the gel is spread on a glass plate and dried under vacuum at 50°C for
25 about 24 hours. Alternatively, the gel may be freeze-dried. Such methods are well known in the art.

Nicotine/carbomer complexes can then be formed into solid dosage forms and a pharmaceutically acceptable
30 coating may be applied, as described above for non-complexed nicotine. For example, the complex may be enterically coated thereby delaying the release of the nicotine/carbomer complex until it reaches the ileum and colon.

35

Alternatively the gel can be incorporated into a suitable liquid enema formulation as described earlier.

The invention will be illustrated by way of the following non-limiting examples, and drawings.

Figure 1 shows mean plasma concentration-time curve during intravenous administration of 15 mcg nicotine/Kg body weight over 15-30 minutes.

Figure 2 shows plasma concentration-time curve after oral administration of 45 mcg nicotine/Kg body weight for each subject with detectable levels (2 subjects had no detectable levels).

Figure 3 shows plasma concentration-time curve after administration via hydrophilic acidic enema vehicle of 45 mcg nicotine/Kg body weight for each subject with detectable levels (2 subjects had no detectable levels).

Figure 4 shows plasma concentration-time curve after administration via hydrophilic basic enema vehicle of 45 mcg nicotine/Kg body weight for each subject with detectable levels (1 subject had no detectable levels).

Figure 5 shows plasma concentration-time curve after administration via hydrophobic acidic enema vehicle of 45 mcg nicotine/Kg body weight for each subject with detectable levels (1 subject had no detectable levels).

Figure 6 shows plasma concentration-time curve after administration via hydrophobic basic enema vehicle of 45 mcg nicotine/Kg body weight for each subject with detectable levels (2 subjects had no detectable levels).

Example 1

The levo(-) form of nicotine base was used to prepare nicotine/carbomer capsules. Nicotine was obtained from Sigma Chemicals at a 98-100% purity and a density of 1.02 g/ml. It was protected from light and stored in a cool place.

Carbopol™ 974P NF (1 g 13.2 mmol carboxylic acid) was mixed with 50 ml of de-ionised water; stirred thoroughly and allowed to stand for 30 minutes at room temperature.

Meanwhile, nicotine (1 g 17 drops from a Pasteur pipette) was diluted in 1 ml absolute ethanol. This solution was then added dropwise to the carbomer suspension and mixed continuously for approximately 10 minutes until a gel of uniform consistency had formed. Visual observation, during this process, noted a gradual thickening of the suspension occurring as neutralisation of the carbopol took place. It was also accompanied by a white appearance of the product. This physical change in viscosity was consistent with neutralisation of the acid by the base.

The gel was then spread on a large glass plate and dried under vacuum at 50°C for 24 hours. The resulting white crystalline material was crushed using a pestle and mortar. The yield was 1.45 g (72.5%) after prolonged drying of the ground crystals.

An alternative method of drying to elevated temperature is freeze-drying. On repeating the above manufacture and freeze-drying the product, the yield increased to 1.65 g (82.5%). This yield increase was probably due to reduced volatilisation of the nicotine component.

35

Larger batches were prepared as follows: 50 g of carbopol powder was weighed and dispersed in 2500 ml of de-ionised water. The dispersion was rapidly stirred using a suitable mixer with a blade-type impeller.

5

The powder was slowly sieved into the vortex created by the stirrer using a 500 micromoler brass sieve. Meanwhile, 1 g of nicotine was accurately measured and diluted with 1 ml of absolute ethanol. After the carbomer powder had been allowed to form a colloidal suspension for 30 min., the stirring speed was greatly reduced to get rid of the majority of air bubbles that had formed throughout the preparation. The alcoholic nicotine solution was then added drop wise into the vortex and stirring continued for 60 min. At the end of this time the batch was freeze-dried. This product could then be used to prepare coated capsules or enemas in accordance with the invention.

20 Example 2

A carbomer colloidal suspension was prepared as described above by dissolving 200 mg to 800 mg, preferably 400 mg of Carbopol™ 974P in de-ionised water. To this suspension was added dropwise a nicotine/ethanol solution (2 to 12 mg nicotine base). A xanthan gum solution of 75 mg to 400 mg, preferably (100 mg of xanthan gum e.g. Keltrol™; 150 mg methyl hydroxybenzoate; and 15 mg propyl hydroxybenzoate) was then added to the complex. Trometamol can optionally be added as a thickening and buffering agent. In this example the pH was then adjusted to 5.5 and the viscosity to 4.35mNa by adding the required quantity of a 1% w/v aqueous trometamol solution. The final volume was adjusted to 100 ml.

When trometamol is used as a buffer instead of e.g. phosphate buffer, the nicotine peak plasma concentration is significantly lowered. Since nausea and other side-effects are induced by peak plasma levels, this decrease
5 further improves the beneficial treatment of the invention.

Example 3

10 Part A:

Delayed-release Eudragit™ coated oral nicotine capsules were prepared by Tillotts Pharma AG, Ziefen, Switzerland and consisted of either 3 mg or 6 mg of
15 nicotine (8.887 mg or 17.774 mg nicotine tartrate base salt, respectively). The nicotine salt was suspended in an excipient (a saturated polyglycolized glyceride; Gelucire™ 44/14, (supplied by Gattefosse France) (190 mg or 380 mg respectively) and filled into hard gelatine
20 capsules (size 1). The capsules were then coated with Eudragit™ L30D. Eudragit™ L30D is a polymer which dissolves at about pH 6.8 in the ileum. The size of the capsule and the thickness of the Eudragit coating are similar to those used to deliver Asacol™ (Eudragit coated
25 mesalamine) to the terminal ileum (Schroeder et al., NEJM, 317:1625-9 (1987)).

Part B:

30 Delayed-release Eudragit coated oral nicotine/carbomer capsules were prepared by Tillotts Pharma. Nicotine/carbomer powder (1:50 - nicotine carbomer) was coated with Eudragit™ L, S or LS. The coated powder was then formed into spherules, coated with
35 Eudragit S and filled into hard gelatine capsules (size 1). The capsules were then coated with Eudragit™ L30D.

In one example, the capsules contained 150mg nicotine-cabomer complex, equivalent to 3mg nicotine base.

Example 4

5 This study compared the bioavailability and pharmacokinetics parameters of nicotine after administration by each of 6 different routes: IV; oral; hydrophilic enema (acidic and basic); and hydrophobic
10 enema (acidic and basic).

Intravenous nicotine was prepared using a nicotine base, supplied as the tartrate salt (Fisher Scientific/Eastman Kodak Company, Rochester, NY).
15 Solutions for injection were made up by combining 1.5 mg nicotine base (4.44 mg tartrate salt) in 100 ml of 0.9% sterile normal saline to form a 15 mcg/mL solution. The intravenous solution was filtered through a 0.22 micron filter into a sterile container and under sterile
20 conditions. The solution was then cultured for organisms, assayed for endotoxin, and chemically analyzed prior to infusion to assure stable nicotine concentration. These samples were then be stored in sealed vials until the time of administration.

25 The oral preparation was formed by dissolving 45 micrograms nicotine base/kg body weight (133.3 micrograms tartrate salt/kg body weight) in 30 ml purified water. This dosage (approximately 3 mg nicotine
30 base for a 70 kg subject) has been well-tolerated in a previous study in which oral nicotine was administered (Benowitz et al., *Clin. Pharmacol. Ther.* 49:270-7 (1991)).

35 The hydrophilic enema vehicle was prepared by combining 500 mg of medium viscosity

carboxymethylcellulose (Spectrum Chemical Manufacturing Corporation, Gardina, CA), 5 g sorbitol (Spectrum Chemical), and 60 mL of water. The sorbitol was added to make the vehicle isoosmolar and the
5 carboxymethylcellulose was used as a suspending agent. The vehicle, described previously (Sandborn et al., *J. Clin. Pharmacol.* 31:76-80 (1991)), was dispensed into 120 ml enema bottles. The active agent, 133.3 micrograms nicotine tartrate salt/kg body weight (equivalent to
10 45 micrograms nicotine base/kg body weight) was added to the enema vehicle.

The hydrophobic enema vehicle was prepared by adding 3 g of Witepsol H-15 (an oleaginous base - Huls American
15 Inc., New Jersey) to the hydrophillic enema vehicle. Enema vehicles were made acidic by adding 5.06 g of sodium citrate dihydrate (Spectrum Chemical) and 0.56 g of citric acid monohydrate (Spectrum Chemical) to create a solution with a pH of 5.5. Enema vehicles were made
20 basic by adding 5.23 g of sodium phosphate (Spectrum Chemical) and 0.05 g of sodium phosphate monobasic (Spectrum Chemical) to create a pH 8.5 solution. The enema vehicles were confirmed to be stable over a 48 hour time period (100% recovery) with a minimal decrease in
25 nicotine concentration when allowed to stand at room temperature over a 3 week period (97% recovery at 1 week, 94% recovery at 2 weeks, 91% recovery at 3 weeks).

Thirty paid human volunteers were admitted to the
30 pharmacokinetic study after giving informed consent to a protocol approved by the institutional review board at the Mayo Clinic, Rochester, MN. The subjects ranged in age from 21-56 and their body weights ranged from 45 to 153 Kg. All subjects were non-smokers and were healthy
35 based on their histories, and physical examination. Subjects agreed to practice birth control during the

study period. Complete blood count, chemistry group, urinalysis and pregnancy test (women only) were obtained.

Subjects were excluded if they had cardiovascular disease, peripheral vascular disease, hypertension, were
5 nursing mothers, had laboratory evidence of pregnancy, or had hepatic or renal dysfunction.

Based on the results of a pilot study of two additional subjects, it was determined that colonic
10 absorption of nicotine is dependent upon patient position, with higher plasma levels detected when subjects were allowed into a sitting position immediately after administration, rather than remaining in the left lateral decubitus position. The first subject studied
15 underwent 3 investigations (IV, 15 mcg/Kg hydrophillic basic enema, 45 mcg/Kg hydrophillic basic enema). During the 15 mcg/Kg enema visit the subject was inadvertently allowed into a sitting position after administration and was found to have an AUC of 17 (ng)(hr)/mL (IV visit AUC
20 18 (ng)(hr)/mL) with a bioavailability of 94%. On the 45 mcg/Kg visit the subject remained in the left lateral decubitus position the entire time the enema was retained and had an AUC of 0 (ng)(hr)/mL with a bioavailability of 0%. Similarly, one subject withdrew from the study after
25 the enema visit (first visit) in which an upright position was taken shortly after administration and side effects occurred. The AUC for this subjects visit was 18 (ng)(hr)/mL. During the remainder of the study, subject position was more closely monitored and plasma nicotine
30 concentrations remained low or undetectable with enema administration.

Each subject underwent 2 investigations (IV and non-IV) of 8 hours duration at least 1 week apart. During
35 the IV visit, subjects were given a 15-30 minute infusion of the IV nicotine solution (15 mcg/Kg dose). During the

non-IV visit subjects were given a 45 mcg/Kg dose of nicotine base via one of five randomly selected delivery routes which were prepared within 48 hours of administration: oral; hydrophillic enema (acidic or basic); hydrophobic enema (acidic or basic). The subjects were instructed to remain in the left lateral decubitus position while the enema was retained and to retain the enema for at least one hour. On each study day, venous blood samples were drawn from an IV catheter into standard chemistry vacutainer tubes. Samples were obtained before nicotine administration and at the following time points (time = 0 was defined as the point at which the nicotine infusion was started or the non-IV dose was administered): 5, 10, 15, 30, 60, 90 minutes, and 2, 3, 4, 5, 6, and 8 hours. Whole blood samples were centrifuged and plasma samples were then stored at -20 degrees Celsius until analysis. Plasma concentrations of nicotine were determined by gas chromatography/mass spectrometry as described by Baskin et al. (*Clin. Chem.*, 31:76-80 (1991)).

For this study, the maximum plasma nicotine concentration (C_{max}) and the time to reach C_{max} (T_{max}) were defined as the highest measured plasma concentrations and the time of the sample, respectively.

The following pharmacokinetics parameters were calculated using standard equations (Gibaldi (ed.) *Pharmacokinetics* 2nd ed, Marcel Dekker Inc., New York 409-17 (1982)): area under the plasma nicotine concentration versus time curve (AUC), bioavailability (F), blood elimination half-life (T_{1/2}), volume of distribution (V_{dss}), and blood nicotine clearance (Cl_b).

The computed bioavailability for each subject was used in an analysis of covariance to compare the five groups. Within subject (IV versus non-IV) variation was

evaluated for each group of 6 subjects using a paired-T test. In addition, data was reviewed for gender variation.

5 Mean plasma nicotine concentrations after IV is shown in Figure 1. Plasma nicotine concentrations after oral, hydrophillic acidic enema, hydrophillic basic enema, hydrophobic acidic enema, and hydrophobic basic enema are shown in Figures 2 through 6, respectively. Nicotine was
10 first detected in the plasma at 30 minutes with oral, hydrophillic acidic enema, and hydrophobic acidic enema administration, 10 minutes with hydrophobic basic enema administration, and 5 minutes with hydrophillic basic enema administration (when detectable levels were
15 present).

The mean values for the pharmacokinetics parameters and statistical probability by analysis of covariance for nicotine administered by each of the various routes are
20 shown in Table 1. No statistical differences were found in Cmax, AUC, and bioavailability when comparisons were made between enema and oral administration; however, Tmax for the hydrophillic basic enemas was significantly earlier than for the other 4 delivery systems. Finally,
25 the mean bioavailability for the various routes of administration are as follows: oral 19%; hydrophillic acidic enema 16%; hydrophillic basic enema 14%; hydrophobic acidic enema 25%; hydrophobic basic enema 15%.

Table 1

	Subjects (n)	AUC ⁺	F	T _{max}	C _{max}
		(ng)(h)/mL	%	hr	ng/mL
Oral	6	9 ± 5	19 ± 10	1.1 ± 0.1	3 ± 1
Hdrphbc Acid	6	10 ± 3	25 ± 7	1.3 ± 0.2	3 ± 1
Hdrphbc Base	6	4 ± 1	15 ± 4	1.1 ± 0.5	2 ± 1
Hdrphlc Acid	6	8 ± 4	16 ± 7	1.4 ± 0.2	2 ± 1
Hdrphlc Base	6	4 ± 2	14 ± 6	0.3 ± 0.1	2 ± 1
P*		0.834	0.830	0.023	0.885

* Analysis of covariance adjusting for baseline.

⁺ Analyzed on the natural log scale.

- 5 IV nicotine studies (n=32) (mean±SD): AUC=12±5 (ng)(hr)/mL; C_{max} = 9±3 ng/mL; T_{max} = 0.3±0.1 h.

Intraindividual side effects occurred during each study, as determined by a
 10 questionnaire filled out every 30 minutes, closely correlated with plasma nicotine concentrations. However, the threshold above which symptoms appeared varied from individual to individual with the nicotine concentration at which side effects first appeared ranging from 2.4 ng/mL to 9.9 ng/mL (although some subjects had nicotine concentrations of > 11 ng/mL without symptoms). When side effects occurred, they
 15 consisted of nausea, lightheadedness, and diaphoresis with variable frequency.

During the course of the study, it was observed that the systemic bioavailability of the enema vehicles appeared to be highly dependent upon the position in which the subject remained while retaining the enema. Subjects that were allowed to sit upright
 20 shortly after enema delivery were observed to have a higher bioavailability than when

remaining in the left lateral decubitus position. This presumably was due to rectal pooling of the enema with absorption directly into the systemic circulation rather than the portal circulation, thereby eliminating first pass metabolism by the liver. By virtue of the positional dependence of this preparation, formulation of a colonic
5 delivery system which could avoid direct absorption by the hemorrhoidal circulation could be beneficial.

In summary, rectally administrated and DRO compositions of nicotine had low bioavailability and was well tolerated. Therefore, nicotine may be administered to the
10 colon as a therapeutic agent for the treatment of nicotine responsive conditions, particularly those given hereinbefore, while reducing the limitations inherent to other modes of administration.

Example 5

15 The aim of this study was to determine nicotine tartrate pharmacokinetics after administration by: IV, and 3 mg and 6 mg eudragit S coated delay release oral (DRO) capsules.

Twenty subjects were randomly assigned to 1 to 2 groups (each n = 10); 3 mg
20 and 6 mg nicotine tartrate DRO. Each subject had 2 studies [DRO and 15 µg/kg (mean 1 mg) IV] separated by ≥ 1 week with the order (IV vs DRO first) randomly assigned. After nicotine administration, blood was obtained for 12 hours and serum nicotine was determined by gas chromatography/mass spectrometry. Plasma cotinine concentrations were determined HPLC in 2 subjects (both 6 mg) over 72 hours.
25 Pharmacokinetic parameters determined were: maximum concentration (C_{max}); time to C_{max} (T_{max}); area under the curve (AUC); bioavailability (F); volume of distribution (V_{dss}); clearance (CL); and half-life (T_{1/2}).

Delayed-release Eudragit coated oral nicotine capsules were prepared in
30 accordance with Example 3, Part A.

Delayed-release Eudragit coated oral nicotine/Carbopol capsules were prepared in accordance with Example 3, Part B.

5 The results of the study are shown in Table 2.

Table 2

Group	No.	AUC ng*h/mL	F %	Cmax ng/mL	Tmax h	Vdss L/kg	CL L/kg/h	T1/2 h
3 mg	10	21±15	41±30	7±6	4.8±1.5			
6 mg	10	42±20	42±20	10±4	5.3±1.1			
IV 1mg	20	20±11	100±0	10±2	0.4±0.1	2±1	1±1	1±1
P		0.02	0.93	0.18	0.38			

The ratios of cotinine AUC after 6 mg DRO and IV nicotine were 1.5
 10 (2036/1401) and 1.6 (3176/2002) for the 2 subjects undergoing cotinine pharmacokinetics, demonstrating significant first pass metabolism.

The results show that nicotine tartrate administered to the ileocolon by the DRO route reduced systemic bioavailability of nicotine, apparently as a result of first pass
 15 metabolism to cotinine. Since systemic cotinine is a less active metabolite than nicotine, this could partly explain the reduced side-effects achieved with the invention.

Therefore a sustained DRO composition of nicotine can be used for the
 20 treatment of nicotine responsive conditions while reducing the side-effects and disadvantages inherent in other known modes of nicotine delivery.

Example 6

Eight normal healthy volunteers and 8 patients with active UC were enrolled in this open label, single dose study.

Enemas were formulated which contained 2, 6 and 12 mg of nicotine, 400 mg of Carbopol, 100 mg of xanthan gum (Keltrol) to increase viscosity, 150 mg methyl hydroxybenzoate and 15 mg propyl hydroxybenzoate and deionised water to make up to 100 ml; phosphate buffer (pH 7.5) was added to produce a final pH of 5.5 with the effect of to increasing nicotines' stability. The nicotine content of sample enemas was first confirmed by diluting a small volume of the contents in dilute hydrochloric acid to produce an approximate concentration of 30 ng/ml, which could then be accurately measured by our assay.

Side-effect experienced by the subjects were recorded as absent, mild, moderate or severe. Subjects were asked to report the time, nature and severity of any symptoms, at the commencement and each hour through the study, and were questioned particularly about nausea, vomiting, light-headedness, tremor, palpitations and headache. Blood pressure and pulse rate were also recorded each hour and when any symptoms occurred.

Five of the subjects, 4 normal and one patient reported side-effects. These occurred in five out of eight females and 5 of the 8 lifelong non-smokers. Those with higher C_{max} values for nicotine and lower body weights were more likely to report side effects. The average onset of symptoms was about 20 minutes after administration of the enema, range 15-30 and lasted for a mean of 58 minutes, range 45 - 70 minutes. All 5 subjects felt lightheaded, 2 also experienced nausea and one had a headache. All symptoms were mild the the exception of one with moderate nausea; they were self limiting and not associated with changes in the pulse rate or blood pressure.

Administration of nicotine to the colon gives particularly few side-effects because only modest rises in serum nicotine occur. Strikingly side effects were few and the preparation well tolerated. The complex of nicotine with a polyacrylic carbomer delays release of the nicotine thereby further contributes to reducing any
5 side effects.

In conclusion, whereas the use of nicotine gum and nicotine patch gave rise (in many patients) to intolerable side-effects, the inventors surprisingly found that absorption from the intestine more preferably delivery to the terminal ileum for
10 colonic absorption (oral delivery), colon (oral and rectal delivery) or rectum (rectal delivery) of this highly toxic drug considerably reduced the side-effects (Table 7).

Without being bound by theory, the inventors believe that the side-effects are related to the maximum peak concentration and the rate of rise of nicotine in the
15 systemic circulation. The low bioavailability of nicotine absorbed through the intestinal mucosa appears to be largely due to its conversion to the major metabolite cotinine on first pass metabolism in the liver. This occurs as the nicotine is taken up in the portal vein from the intestine to the liver before entering the systemic circulation. Thus the high peak plasma levels which are normally responsible for the
20 adverse effects associated with nicotine are limited and therefore nicotine can be used therapeutically in a safer and more convenient manner.

When the nicotine is delivered in the form of a complex with polyacrylate, and/or with gelucire, particularly as a DRO composition, the plasma levels are further
25 limited thereby further decreasing any remaining side-effects and increasing patient comfort. Furthermore when trometamol is used as a buffer in a nicotine-carbomer enema there appears to be some unexplained synergy in that the peak plasma levels and thus side-effects are minimised so that even slightly built patients are not troubled by side-effects.

30

All publications, patents and patent documents are incorporated by reference herein, as though individually incorporated by reference. The invention has been described with reference to various specific and preferred embodiments and techniques. However, it should be understood that many variations and modifications
5 may be made while remaining within the spirit and scope of the invention.

CLAIMS

1. Use of nicotine and pharmacologically acceptable derivatives and metabolites thereof in the preparation of a medicament which is adapted for absorption from the small and/or large intestine for the treatment or prophylaxis of inflammatory skin conditions, schitzophrenia, Alzheimers disease, Parkinson disease, Tourettes syndrome, depression, or to assist in the cessation of smoking.
2. Use as claimed in Claim 1 wherein the medicament is adapted for predominant absorption from the colon.
3. Use as claimed in claims 1 or 2 wherein nicotine is complexed with a polyacrylic acid polymer.
4. Use as claimed in Claim 3 wherein the polyacrylic acid is a carbomer.
5. Use as claimed in any one of the preceding claims wherein the dosage of nicotine is about 1mg to about 36mg.
6. Use as claimed in any one of the preceding claims wherein the medicament is a post-gastric delayed release oral (DRO) composition.
7. Use as claimed in Claim 6 wherein the composition is a sustained and DRO composition.
8. Use as claimed in Claim 8 wherein the sustained release of the nicotine is at least partially achieved by a nicotine-polyacrylate complex as defined in Claims 3 or 4 or nicotine in an excipient of a saturated polyglycolized glyceride or a combination of both.

9. Use as claimed in Claim 9 wherein the polyglycolized glyceride excipient is gelucire^(TM).
10. Use as claimed in any one of Claims 6 to 9 wherein the DRO composition
5 contains an enteric coating for dissolution in the terminal ileum.
11. Use as claimed in Claim 10 wherein the enteric coating is Eudragit.
12. Use as claimed in Claim 11 wherein the composition is an enteric coated capsule
10 of Eudragit L comprising a nicotine-polyacrylate complex in a polyglycolized glyceride excipient.
13. Use of a sustained release form of nicotine or a pharmaceutically acceptable salt in the preparation of a sustained post-gastric delayed release oral composition which
15 contains the nicotine in an enteric coated capsule which dissolves in the terminal ileum, in the treatment or prophylaxis of inflammatory skin conditions, schitzophrenia, Alzheimers disease, Parkinson disease, Tourettes syndrome, depression, or to assist in the cessation of smoking.

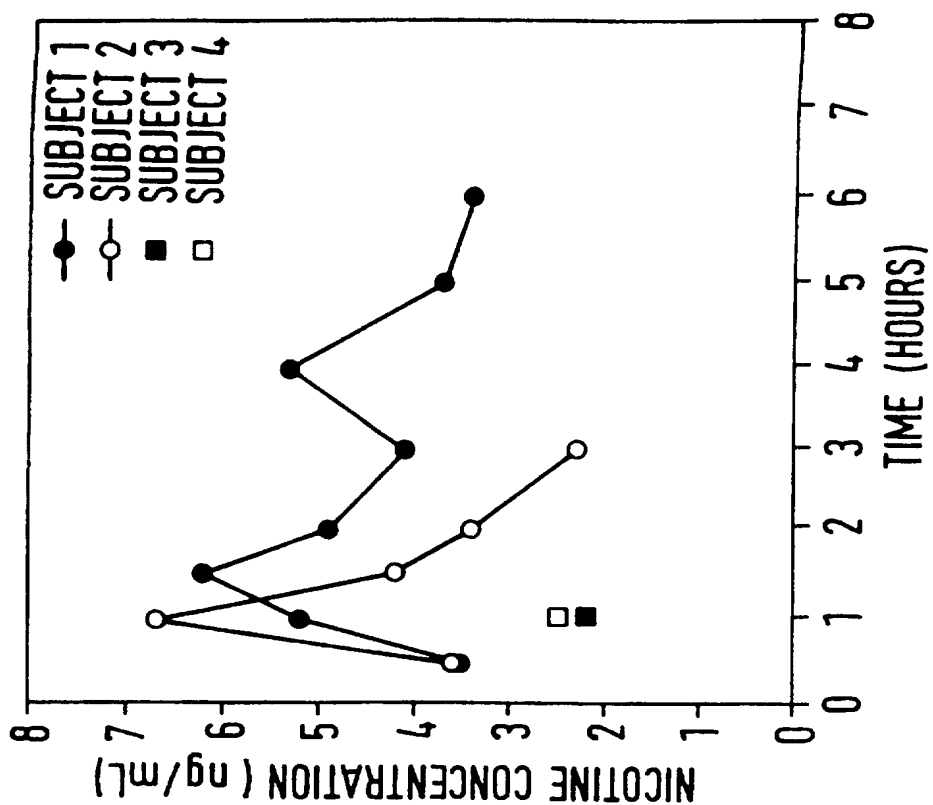


FIG. 2

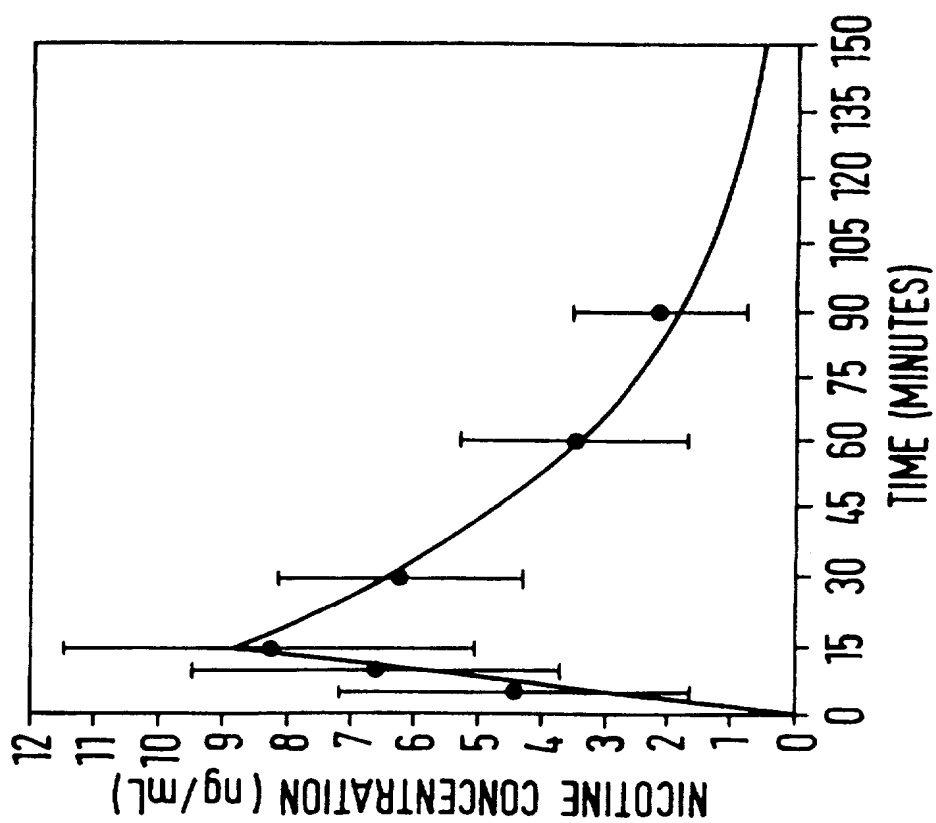


FIG. 1

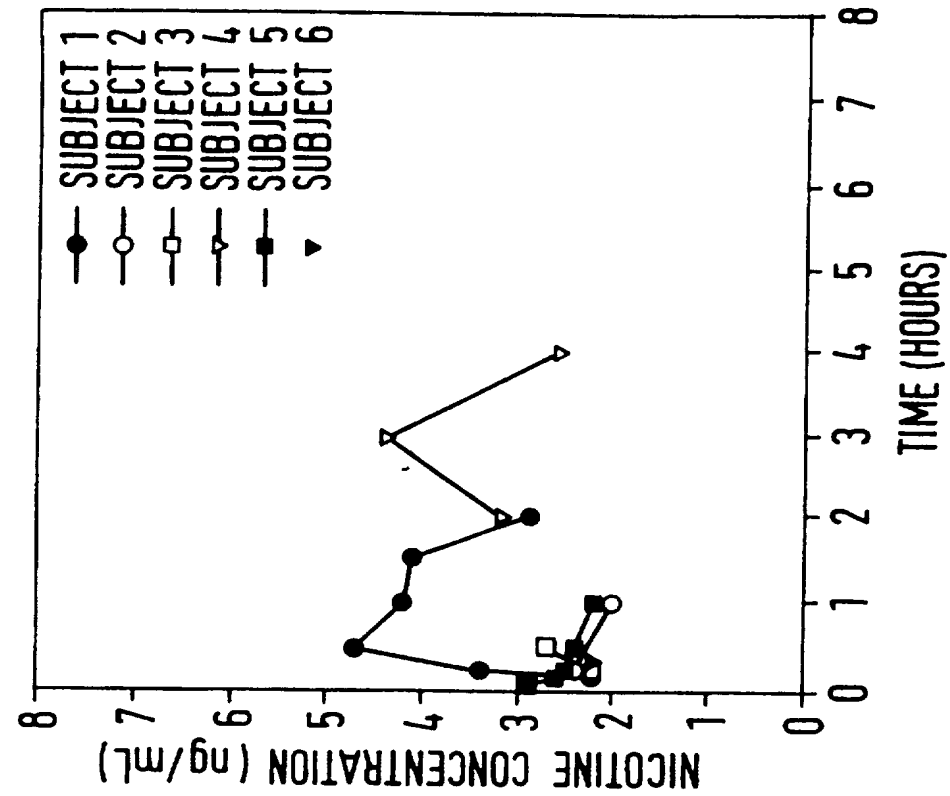


FIG. 4

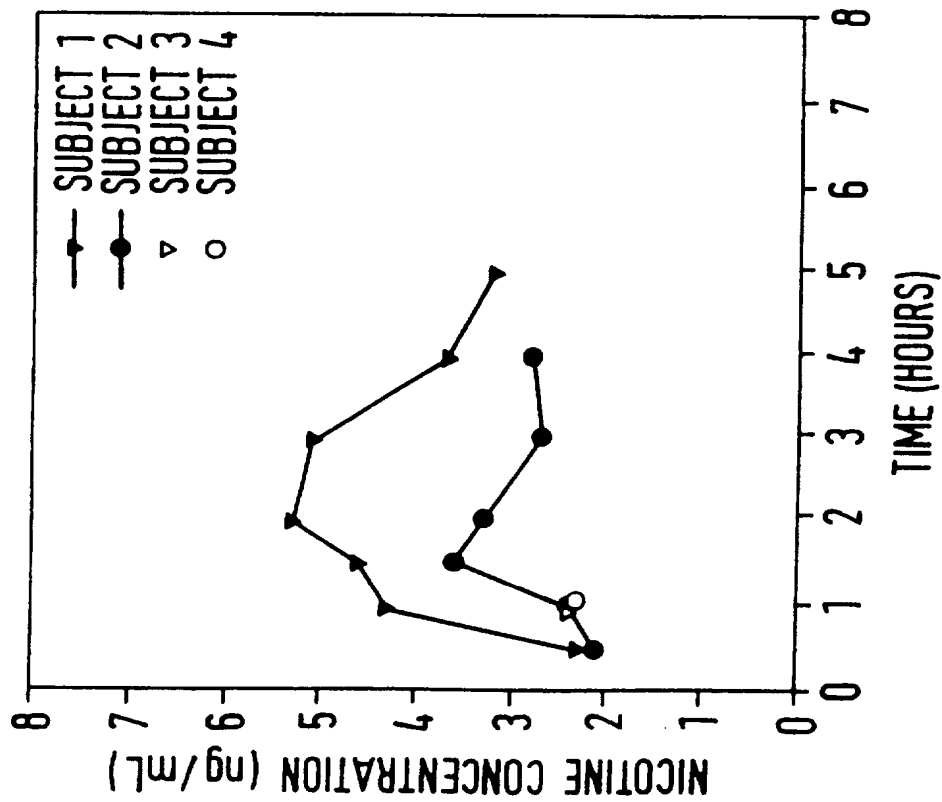
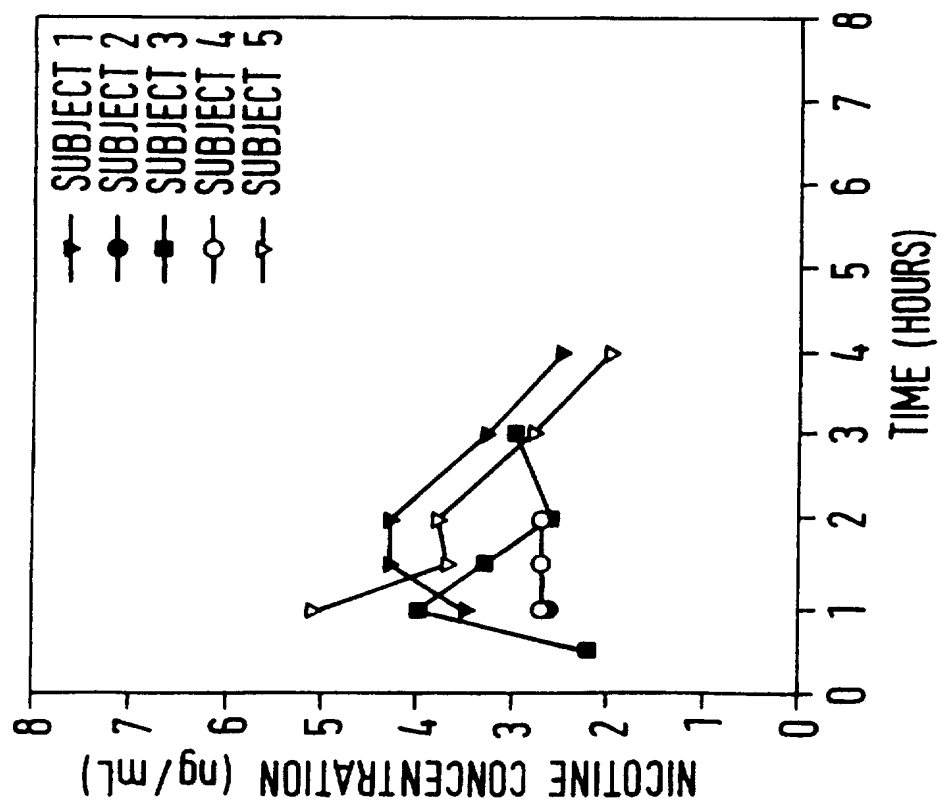
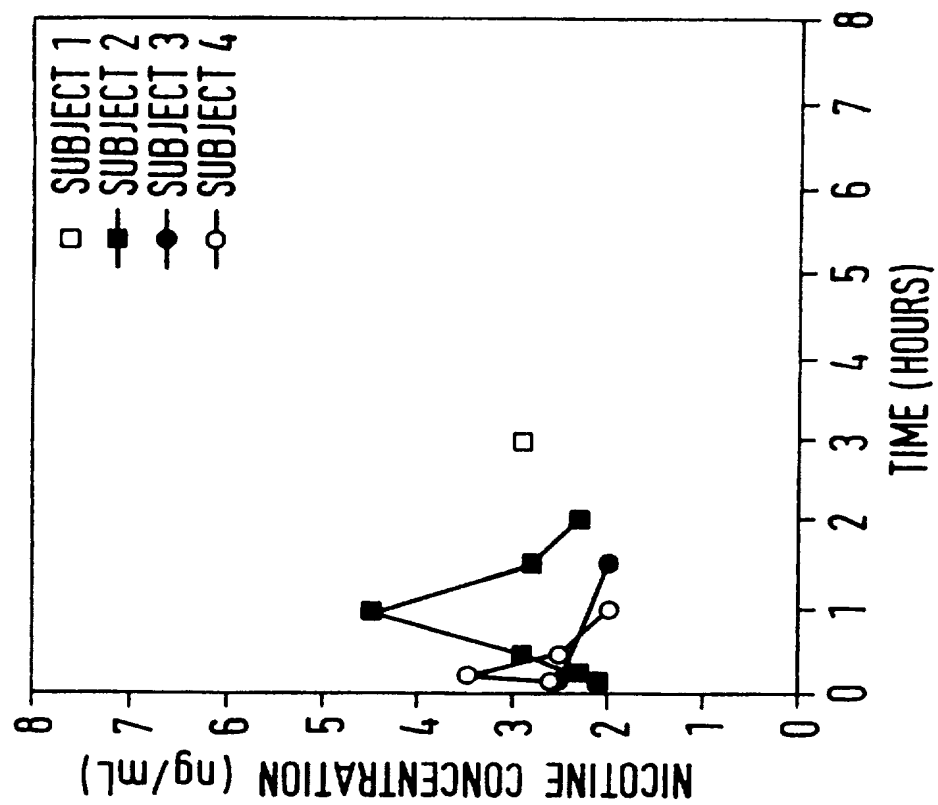


FIG. 3



INTERNATIONAL SEARCH REPORT

International Application No

PCT/GB 97/01938

A. CLASSIFICATION OF SUBJECT MATTER

IPC 6 A61K47/48 A61K31/465

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

IPC 6 A61K A61L

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
E	WO 97 28801 A (MAYO FOUNDATION) 14 August 1997 see the whole document ---	1-13
P,X	GONG ET AL: "Preparation and characterization of a rectal nicotine formulation containing a bioadhesive" PHARMACEUTICAL RESEARCH, vol. 13, no. 9, 1996, page S222 XP002045529 see abstract --- -/-	1-4,8

☒ Further documents are listed in the continuation of box C.

☒ Patent family members are listed in annex.

* Special categories of cited documents :

"A" document defining the general state of the art which is not considered to be of particular relevance

"E" earlier document but published on or after the international filing date

"L" document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)

"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art.

"&" document member of the same patent family

Date of the actual completion of the international search

3 November 1997

Date of mailing of the international search report

20.11.1997

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INTERNATIONAL SEARCH REPORT

International Application No.

PCT/GB 97/01938

C.(Continuation) DOCUMENTS CONSIDERED TO BE RELEVANT

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
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